PROPOSAL FOR A SECTION 1915(B)(4)
INITIAL SELECTIVE CONTRACTING WAIVER PROGRAM

Definitions:

Client: *Means Department of Social and Health Services (DSHS) clients determined eligible to enroll for disease management services with one of the contracted DMOs.*

Enrollee: *Means an individual eligible for one of the medical programs described below who is enrolled in the Disease Management Program through a Disease Management Vendor having a contract with DSHS.*

DM Program: *Means the Disease Management Program, that provides education and certain case management functions to eligible Medicaid clients with asthma, congestive heart failure, diabetes and/or End Stage Renal Disease/Chronic Kidney Failure*

Disease Management Organization (DMO): *Means a company contracted with the Department of Social and Health Services to provide DM Program services to eligible clients.*

Provider: *Means a medical provider or practitioner, responsible for providing medical services to DSHS clients on a fee-for-service basis.*

I. INTRODUCTION

Please provide a short narrative description, in one page or less, of your program, the background to your program and any other information relating to your request for a Medicaid Waiver.

Response*: In 2001, the Washington State Legislature directed the Medical Assistance Administration (MAA) to implement a disease management program for Medicaid clients with chronic diseases. Clients eligible for the program are among MAA's highest cost clients. Many of these clients have multiple conditions, such as mental health and chemical dependency issues, developmental disabilities and other health conditions that complicate the client's primary medical condition. Lack of preventive care and education to help the client effectively manage their disease causes unnecessary hospitalizations and inappropriate use of emergency room services. The goal of the disease management program is to reduce costs to the state and improve the health and quality of life for the clients enrolled in the program through education and increased access to regular preventive care.*

The State will provide a statewide Disease Management Program to Medicaid clients eligible for Title XIX Medicaid coverage under the Categorically Needy Program (CNP), who receive services through the MAA's fee-for-service system, and who have a primary diagnosis of one or more of the following diseases:

- *Asthma;*
- *Congestive Heart Failure;*
- *Diabetes;*
- *End State Renal Disease or Chronic Kidney Disease.*

The State's Disease Management Program is designed to assist enrollees with chronic illness to achieve the following goals:

1. *Increase the enrollee's and/or their caregiver's understanding of their disease so they are:*

    - *More effective partners in the care of their disease;*
    - *Better able to understand the appropriate use of resources needed to care for their disease(s);*
    - *Able to identify when they are getting in trouble earlier and seek appropriate attention before they reach crisis levels; and*
    - *More compliant with medical recommendations.*

2. *Improve enrollees quality of life by assisting them in self-managing their disease and in accessing regular preventive health care;*

3. *Provide coordination among multiple case managers and health care providers;*

4. *Improve adherence to national, evidence-based guidelines to improve enrollees' health status; and*

5. *Reduce <u>unnecessary</u> emergency department visits and hospitalizations.*

6. *Assist enrollees to find a "medical home" if they do not already have one.*

Currently, the state contracts with two Disease Management Organizations (DMOs). Renaissance Health Care Inc. (Renaissance) provides disease management to Medicaid clients with End Stage Renal Disease (ESRD) and Chronic Kidney Disease (CKD), and McKesson Health Solutions, LLC (McKesson), provides a 24/7 Nurse Advice toll free line for the 173,835 Medicaid clients in the eligibility group, and disease management services for clients with Asthma, Diabetes and Congestive Heart Failure (CHF).

II. GENERAL DESCRIPTION OF THE WAIVER PROGRAM

A. The State of Washington (State) requests a waiver under the authority of Section 1915(b)(4) of the Social Security Act (the Act). The waiver program will be operated directly by the Medicaid agency.

B. Effective Date: This waiver is requested for a period of 2 years; effective ***April 10, 2003 and ending April 9, 2005.***

C. The waiver program is called the ***Washington State Disease Management Program***.

D. Geographical Areas of the Waiver Program:

1. The waiver will be implemented ***Statewide***.

E. State Contact: The State contact person for this waiver is ***Alison Robbins***, who can be reached at ***(360) 725-1634 or robbiaa@dshs.wa.gov***.

F. Statutory Authority: The State's waiver program is authorized under ***Section 1915(b)(4) of the Act*** under which the State restricts the provider from or through whom a recipient can obtain medical care.

G. Relying upon the authority of the above section(s), the State would like waiver of the following Sections of 1902 of the Act:

1. ____ **Section 1902(a)(1)** – Statewideness – This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State. (See Appendix II.D. (2)).

2. _X_ **Section 1902(a)(10)(B)** – Comparability of Services – This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid recipients not enrolled in the waiver program.

3. _X_ **Section 1902(a)(23)** – Freedom of Choice – This section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, individuals in this waiver are constrained to receive waiver services from selected providers.

4. ___ **Other Statutes Waived** – In Appendix II.G.4, please list any additional section(s) of the Act the State requests to waive, including an explanation of the request.

H. **Recipient Figures**: Please indicate the expected number of Medicaid recipients that will be impacted by the waiver: ***The waiver program will impact approximately 173,835 Medicaid recipients***.

I. **Waiver Populations**: The waiver is limited to the following target groups of recipients. Check all items that apply:

1. __X__ **TANF** – Temporary Assistance to Needy Families

2. __X__ **TANF-related**

3. __X__ **SSI** – Supplemental Security Income and SSI-related.

4. ____ **Other** – Please describe these other populations in Appendix II.I.4.

J. **Excluded Populations**: The following recipients are excluded from participation in the waiver:

1. __X__ Have Medicare coverage, except for purposes of Medicaid-only services;

2. __X__ Have other insurance ***that provides a comparable disease management program***;

3. __X__ Are residing in a nursing facility of an Intermediate Care Facility for the Mentally Retarded (ICF/MR);

4. __X__ Have an eligibility period that is less than 3 months;

5. __X__ Have an eligibility period that is only retroactive;

6. __X__ Are eligible as medically needy;

7. __X__ Are eligible as foster care children;

8. __X__ Participate in a home and community-based waiver, or;

9. __X__ Have other reasons which may exempt recipients from participating under the waiver program. Please explain those reasons below:

Response: *Medicaid clients who are enrolled in the State's Healthy Options program or who receive comparable case management services from another program, such as HIV/AIDS case management services, are excluded from enrollment in the DM Program.*

K. **Distance/Travel Times**: Please define your access standards for distance/travel times for recipients to receive services.

Response: DM Enrollees do not travel to appointments.

McKesson Health Solutions will provide approximately 90% of its DM services via the telephone. They anticipate that about 10% of their enrollees require more intensive case management and coordination services than can be provided over the phone. To serve these enrollees, McKesson subcontracts with Specialty Disease Management Services (SDMS), who provides the DM services face-to-face in the enrollee's own home, or wherever it is most convenient for the enrollee. SDMS has 18 local nurses on staff, each of which has responsibility for no more than 125 enrollees. The telephonic nurses have responsibility for no more than 250 Washington Medicaid enrollees. The amount of contact that each MCK enrollee has with his or her disease management nurse (whether telephonic or face-to-face) depends on the assessed level of severity of the enrollee's condition.

Renaissance Health Care provides a face-to-face program to all ESRD clients enrolled in the program. The program services are provided in the dialysis centers during dialysis appointments, or the in the enrollee's home if it is necessary. Renaissance has four nurses who provide services in the dialysis facilities, who support an average of 40 enrollees. As with the McKesson program, the amount of contact each enrollee has with his or her disease management nurse depends on the assessed level of severity.

L. **Independent Assessment**: The State will arrange for an Independent Assessment of the cost-effectiveness of the waiver and its impact on recipient access to care of adequate quality. **This assessment is to be submitted to CMS 6 months prior to the end of the waiver period**. Entities that may perform the assessment include universities, actuaries, etc. Examples of independent assessments are available upon request.

NOTE: *Milliman USA will do a cost effectiveness assessment of the program. The University of Washington will do a program assessment in coordination with the Oregon Medical Professional Review Organization (OMPRO) and the State's Medical Eligibility Quality Control Section (MEQC). Additionally the MEQC will do a survey of client satisfaction with the program at six months, and after one year of program operation.*

M. **Automated Data Processing**: Federal approval of this waiver request does not obviate the need for the State to comply with the Federal automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C; 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

III. PROGRAM IMPACT

In this section, please provide information on (1) affected recipients, (2) services, and (3) waiver providers.

A. **Affected Recipients**

1. **Notification Process**: Please explain in detail the process through which recipients will be notified of the waiver program provisions.

Response: *All clients in the eligibility group of 173,835 clients receive notification of their ability to access the nurse advice line provided by McKesson (A copy of the brochure is attached as* ***Appendix III.A.1.a****).*

*Additionally, clients who have one or more of the four disease states being served by one of the DMOs are automatically assigned to the appropriate DMO using client eligibility and claims data to determine the client's eligibility and primary diagnosis. This process is described in more detail in Section A.2. Clients who have been assigned to one of the DMOs receive an introductory letter (****Attachment III.A.1.b****) from the State, briefly describing the program and informing the client that they will be receiving a packet of information and a telephone call from one of the two contracted DMOs. The introductory letter from DSHS also describes the process for "opting out", (disenrolling) from the program, and the processes for filing a complaint or requesting a fair hearing.*

*The informational packet sent by the DMOs (****Attachment III.A.1.c****.) describes the program in more detail. The follow-up telephone call is used for the initial client assessment, and to answer any questions the client has.*

All clients in the eligibility group of 173,835 have access to both the McKesson nurse advice line and the state's toll free Medical Assistance Customer Service Center (MACSC) line.

2. **Recipient's Choice of DMOs**: If more than one DMO is selected per geographical area, please address the following points below:

(a) Will clients be given the choice of selected DMOs? If so, how will they select a DMO, and how will the DMO be informed of the recipient's choice?

(b) How will enrollees be counseled in their choice of Waiver providers?

(c) How will the recipient notify the State of provider choice?

(d) Define the time frames for recipients to choose a waiver provider.

(e) Will the recipients be auto-assigned to a waiver provider if they do not choose? Yes___ No____

(i) If so, how many days will they have to choose?

(ii) Describe the auto-assignment process and/or algorithm.

The requirement for choice of DMO is being waived.

Clients are assigned to one of the two DMOs based on the client's primary diagnosis. Clients are determined eligible for the Diabetes, Asthma, CHF and ESRD/CKD portions of the DM program using client eligibility and claims data to determine the primary diagnosis. McKesson receives a client eligibility list showing all 173,835 clients in the eligibility group, and Renaissance receives information about only those clients enrolled in the ESRD/CKD program.

All clients with one of the four disease states are eligible to participate in the condition-specific disease management program and are automatically assigned to the appropriate DMO. Although clients will not have a choice of DMOs McKesson enrollees will be able to change telephonic disease management nurses if necessary. To date, McKesson has not received a request to change DM nurses for any of their lines of business. However, they do have a policy for making changes if needed. For a confrontational interaction during a disease management call, the call will be completed and the nurse will contact his or her supervisor to review the case and reassign as needed. Each case will be individually evaluated.

For the nurse triage line, if the nurse enters into a confrontational interaction, the nurse contacts a peer to get the supervisor to take over the call. Calls are not dropped but held until the supervisor can intervene.

Both the State and the DMOs occasionally receive referrals either from Medicaid providers or from the client themselves, asking for enrollment in the program. Eligible clients are also found via the nurse advice line. Although clients may use the nurse advice line for asking any health related questions, as part of the call the triage nurse asks a series of questions to determine whether the client has one of the four diseases served by the DM Program. These referrals are researched to verify eligibility and diagnosis, and if the clients meet the program requirements, they are enrolled in the program.

3. **Implementation Process**

(a) Will implementation occur all at once?

____ Yes Please explain.

__X__ No Please describe the time frames for implementation, including time frames for inclusion of current Medicaid recipients.

***Response**: The program is currently implemented statewide for all services and disease states.*

The asthma and ESRD programs began in April 2002. The ESRD Program began in Western Washington and expanded to Eastern Washington on June 1, 2002. Renaissance added services for clients with CKD on July 1, 2002, and McKesson implemented the nurse advice line and provision of services to clients with diabetes and CHF on July 1, 2002.

(b) Will there be accommodations for special-needs populations such as the disabled, etc?

__X__ Yes Please explain.

____ No

***Response**: For those enrollees who require a more intensive level of services than those provided by the nurse triage line, the intent of the DM Program is to serve clients with special needs. As has been described, the contracted DMOs are required to provide services that fit the needs of each client. The program is not intended as a "one size fits all" program. In addition to the services provided in the dialysis centers (Renaissance) or via telephone (McKesson), the DMOs will provide face-to-face disease case management services for their enrollees in the enrollee's home when the client's risk level requires more intensive contact, and will work with state staff to assist the enrollee in obtaining services provided by medical providers and other community agencies. The DMOs will assist enrollees who have multiple case managers within DSHS to ensure all case managers are aware of the enrollee's needs, as well as the existence of other case managers, and will help to coordinate services among the case managers if necessary.*

4. **Educational Materials**: Please describe all relevant recipient education materials, including the **initial notification letter** from the State. Also, check the items that will be provided to the recipients.

NOTE: Please see the materials attached as Attachments III.A.1.a, b. and c.

(a) __X__ A brochure explaining the program.

(b) ____ If more than one provider is selected per geographical area, a form for selection of a provider.

(c) ____ If more than one provider is selected per geographical area, **a list of qualified providers** serving the recipient's geographical area;

(d) ____ A ***new*** **Medicaid card** which includes the provider's name and telephone number or a ***sticker*** noting the provider's name and telephone number to be attached to the original Medicaid card (please specify which method);

(e) __X__ **A brief presentation and informing materials** to each new recipient describing how to appropriately access services under the waiver program; and

(f) __X__ Other items (please explain below):

All clients in the eligibility group of 173,835 with three consecutive months or more of eligibility receive an introductory packet of information about the toll-free nurse advice line that includes a refrigerator magnet with the 800 number.

Clients who have been determined eligible for the DM Program in addition to the nurse advice line receive an informational letter from the State. In addition, the DMOs provide information packets, and either an introductory telephone call and assessment, or for those who need it, a face-to-face meeting and assessment. Renaissance Health care schedules appointments with enrollees during their dialysis appointments to provide information about the program, initial assessment, and ongoing education and case management services where needed.

5. **Languages**: The State has made a concerted effort to determine if and where significant numbers (10% or more) of non-English speaking recipients reside, and has subsequently made the program education materials available in the native languages of those groups.

Response: *The State and the contracted DMOs provide all client materials in the format and language most appropriate to the client, whether or not there is a concentration of any particular language in an area. The Contractors must provide all generally available and client specific written materials in a form that may be understood by each individual client. This may include translating the materials into*

the client's primary reading language; providing the material on audiotape in the client's primary language; having an interpreter read the client the materials or providing materials in an alternative format such as Braille or large print format. The Contractor's may also document that the client has chosen to receive client materials in English. If it is not known whether the client's has a primary language other than English, the Contractors include directions in each of the most common primary languages for accessing needed DM services. ***Please see Attachment III.A.5.***

The DMOs are also responsible for obtaining State funded interpreter services when necessary. DMOs use contracted interpreters when available, or may use telephonic interpreters such as the AT&T Language Line if an in-person interpreter is not available.

B. **Services**

1. **Description of Services**

Please identify the Medicaid services that will be affected by the selective contracting process:

Response: *The DM program is new to Washington and will provide services not previously available to fee-for-service Medicaid clients. The DMOs will provide education and necessary coordination to enable fee-for-service Medicaid clients to access needed medical care to prevent unnecessary emergency department services and hospitalizations.*

While the contracted DMOs do not provide direct medical care such as preventive care, authorization or denial of referrals or emergency care, or inpatient hospital services, they provide a wide array of educational and support services further described in the Contract, Sections III.A, III.B, and III.C. The Contracts and amendments for the four disease states are attached as ***Attachment III.B.1.***

2. **Emergency and Family Planning**: In accordance with regulations, freedom of choice of provider in cases of emergency and family planning services will not be restricted.

NOTE: *This DM program does not cover emergency services or family planning, so will not restrict clients access to or choice of providers for either of these services.*

The DMOs will be monitored to ensure that freedom of provider is protected whenever access to services is discussed by staff on the nurse triage line or by nurse case managers. Regular reports on the

nurse triage line include numbers of clients directed to urgent care, emergency care, or back to their own providers.

C. **Selection and Availability of Providers**

This section describes:

1. *The criteria used to select DMOs for the Disease Management (DM) Program;*

2. *The number of DMOs available before and after the implementation of the DM Program;*

3. *The number of Nurse Case Managers available to serve enrollees; and,*

4. *The conditions under which a DMO or Nurse Case Manager may request an enrollee's disenrollment from the DM Program. (For the purposes of this program, disenrollment is defined as the enrollee no longer participating in the DM Program, not as the enrollee switching from one DMO to the other.)*

   Disease Management services for fee-for-services Medicaid clients began in Washington with the implementation of MAA's Disease Management Program in April of 2002. Prior to April, there was no system-wide approach to providing education and medical case management to the State's high cost clients with chronic health conditions; and no coordinated means of coordinating fee-for-services clients care among medical providers and case managers.

   The two DMOs that were selected met the criteria detailed below, and further described in the State's Request for Proposals (RFP), attached as ***Attachment III.C.1.*** *and the evaluation criteria labeled* ***Attachment III.C.1.a****. DMOs are paid by the state on a capitated basis; McKesson is paid per disease state on a "population-based" capitation that includes the Nurse Triage 1-800 Services for all 173,835 clients in the eligibility group, and Renaissance is paid a capitated rate based on the actual number of enrollees in the ESRD/CKD program.*

   In the State's competitive procurement process, vendors wishing to contract with the Medical Assistance Administration to provide disease management services were required to meet the following conditions:

   (a) Have an appropriate method for using MAA healthcare data to identify targeted disease populations;

(b) Have an evidence-based healthcare practice guideline for each targeted disease;
(c) Have collaborative healthcare practice models in place to include MAA's contracted physicians and support-service providers;
(d) Have patient self-care management education materials and methods appropriate to each targeted disease population;
(e) Have process and outcomes measurement, evaluation, and management systems;
(f) Have routine reporting processes that are proven to properly support disease management goals; and
(g) Have demonstrable and successful experience in disease management for the targeted disease populations.
(h) Provide access to a 24 hour-a-day, seven days-per-week nurse call center;
(i) Have the ability to guarantee program savings.
(j) Meet applicable federal and state laws and regulations governing the participation of providers in the Medicaid program.
(k) Not refuse to provide services to a waiver participant or otherwise discriminate against a participant solely on the basis or age, sex, race, physical or mental handicap, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider type.

Additionally, all Disease Management Nurse Case Managers are required to be registered nurses who meet the requirements of the contracted disease management vendors. All Washington based case management nurses are licensed in the State of Washington. Additional services may be provided by Registered Respiratory Therapists licensed in the State of Washington.

Because the two contracted DMOs provide services to clients with different disease states, the State is waiving choice of provider in the DM program. DM enrollees do not have a choice of DMO, except in the case of McKesson enrollees who develop CKD or ESRD – they may choose to stay enrolled with McKesson or may switch to the Renaissance program.

Renaissance Health Care provides services to clients who have CKD or ESRD. Services are provided by Renaissance nurses who work from their homes, but provide most contracted services in the dialysis centers, usually during the enrollees dialysis appointments. The Renaissance Nurse Case Managers also make telephone contact with their assigned enrollees on a regular basis, the frequency of which is determined by the client's assessed risk status. The ESRD Nurse Case Managers serve an average of 40 clients, assigned on a

regional basis. Renaissance has also hired a Nurse Case Manager to work with CKD enrollees when they begin enrolling in the program.

McKesson Health Solutions provides the Nurse Advice Triage telephone service to all 173,835 clients in the eligibility group. Enrollees may call the Triage service at any time 24 hours-a-day, seven-days-a-week, with either a question about their disease state or any other health question or problem they have. The Triage service is also used as a screening tool to find possible enrollees for the DM Program. The Triage service is staffed by 400 registered nurses and staffing is increased as demand increases.

McKesson also provides DM program services to enrollees with asthma, diabetes and Congestive Heart Failure (CHF). DM Program services are provided either by registered nurses via telephone, or, for enrollees who have been assessed as greater risk or with multiple health problems, face-to-face. Face-to-face services are provided by local nurses hired by McKesson's subcontracted provider, Specialty Disease Management Services (SDMS).

The nurse to enrollee ratio for the telephonic program is approximately 1-250, and the local face-to-face program has a ratio of no more than 1-125. The State provides ongoing monitoring via contractor reports and the State's Complaint Management Information System (CMIS), to ensure that nurse to enrollee ratios are such that each enrollee obtains DM services appropriate to that enrollee's risk level.

The DMOs may request a disenrollment for an enrollee under very limited circumstances; however, under no circumstances may the DMO request a disenrollment because of a change in the enrollee's health status or cost of providing services to the enrollee. The DMO may request a disenrollment in the following circumstances:

1) The DM enrollee does not meet eligibility requirements to participate in the DM Program;

2) The enrollee's behavior is such that DMO feels the enrollee is threatening the health and safety of their staff. A disenrollment is granted by the state when the DMO documents their concerns and makes the disenrollment request to the State.

Enrollees who are unable to develop a productive relationship with his or her telephonic Nurse Case Manager may request a switch to a different nurse. However because of the "regional" nature of the Nurse Case Managers hired locally to provide DM Program services, it is more difficult to facilitate a switch from one nurse to another for in-person case management. Both DMOs have processes in place

to assist enrollees in finding the appropriate Nurse Case Manager or to resolve problems between enrollees and nurses.

IV. ACCESS TO CARE AND QUALITY OF SERVICES

A. **General**: The enrollee's access to quality medical services must at a minimum, not be adversely affected by a 1915(b)(4) waiver program. A waiver must assure an adequate amount of services during reasonable time periods and within reasonable geographic distance from the residences of the individuals enrolled under the waiver. Furthermore, access to emergency services and family planning services must not be restricted.

***NOTE**: The waiver program will not limit enrollees' access to care. The goal of the program is to help ensure that enrollees receive adequate care to improve their quality of life and adherence to national care guidelines for their disease. Enrollees will have regular contact with their DM nurse case manager, and will also have 24/7 access to a nurse advice line for questions and care issues.*

B. **Grievance Process**: Please describe the process that will be in place to handle complaints and grievances under the waiver program. Please discuss how this will compare to the regular Medicaid program. NOTE: Enrollees must have available and be informed of a formal appeals process under 42 CFR Part 431. Subpart E which may lead to a Fair Hearing.

As described in Appendix IV.B, The State will take the primary role in complaint and grievance resolution, but will coordinate with the DMOs to ensure that all factors are taken into consideration when resolving the complaint or grievance. This is the process used for fee-for-service clients as well as those enrolled in DMOs.

The introductory letter sent by DSHS describes the process for "opting out", (disenrolling) from the program, and the processes for filing a complaint or requesting a fair hearing.

C. **Monitoring Access and D. Monitoring Quality**

Because the methods used to monitor access to care and quality of services will be the same, Sections C. and D. of this section have been combined to reduce duplication.

***NOTE:** Because DM enrollees do not travel to receive program services, the State will not monitor time and distance, nor will the State monitor access to emergency services, except to validate contractor reports that program enrollees are not diverted from using emergency services when needed. This will be accomplished by MEQC surveys and the University of Washington's program evaluation.*

Prior to implementing the DM program the State established an advisory committee to ensure that enrollee and provider concerns were addressed and that resources within the Medical Assistance Administration (MAA) were allocated to provide adequate support to program staff in determining client eligibility, developing client materials and in development of the savings guarantees and clinical outcome measures. The steering committee continues to provide oversight of program activities.

Monitoring Activities

The State will use several methods to monitor access to and quality of services provided to DM enrollees, including:

- *Surveys conducted by the State's Medical Eligibility Quality Control (MEQC) unit;*
- *Surveys conducted by the DMOs;*
- *State review of DMO records;*
- *Independent evaluation of the program by the University of Washington (UW),*
- *Regularly scheduled conference calls between the State and the DMOs; and*
- *Quarterly on-site meetings between the State and DMOs, including a yearly on-site monitoring visit to each of the DMOs.*

The surveys conducted by the MEQC include questions addressing:

- *Whether the enrollee has been contacted by the DMO,*
- *The accessibility of the enrollee's DM nurse;*
- *The enrollee's ability to access the McKesson Nurse Triage line that is available to all clients in the eligibility group of 173,000, and the State's toll-free customer service line,*
- *The enrollee's knowledge of how and when to access these services, and;*
- *The enrollee's satisfaction with the services received.*

As part of the MEQC survey process, "Problem Reports" will be sent to the DMOs via DM program staff. The Problem Reports are developed from enrollee responses to the surveys. The DMOs have the opportunity to research the Problem Reports and report on their findings to the State during a debrief of the survey process.

The surveys conducted by the DMOs will include similar questions and will be conducted on no less than a yearly basis.

Additionally, the State's toll free Medical Assistance Customer Service Center (MACSC) hotline is available to DM enrollees who have questions or complaints about the program, and requests for enrollment or disenrollment. Data about all calls received by the MACSC line are kept to track complaints

and their resolution. Data regarding the number and reasons for disenrollment requests are also tracked on a regular basis.

The State and the DMOs have regular meetings. Meetings are conducted telephonically on a bi-weekly basis with both vendors, to discuss ongoing issues and problems. Additionally, quarterly meetings are held on-site, alternating between State offices in Washington and the two DMOs offices in Colorado.

As one of the quarterly meetings, the State will conduct a monitoring visit to the DMO's facilities. The on-site monitoring visits will include:

- *Medical record review;*
- *Observation of the telephonic disease management calls to Medicaid enrollees (McKesson);*
- *Observation of triage calls made to McKesson's nurse advice line;*
- *Review of complaint and grievance logs; and*
- *The results of the contractor's enrollee and provider satisfaction surveys.*

On an ongoing basis, the State will monitor contractor performance by:

- *Tracking complaints made to the State's customer service center, or forwarded to DM program staff by the DMOs;*
- *Number and reasons for "opt-outs" (disenrollments) for clients who were enrolled in the program and chose not to participate;*
- *Enrollee and provider satisfaction surveys conducted by the MEQC;*
- *Reports submitted by the DMOs; and*
- *Regularly schedule telephonic meetings between DMO staff and the State.*

D. **Other Quality Monitoring**

1. **Quality of Services** will be further monitored through the mechanisms outlined in Appendix IV.E.1. Quality of services problems identified will result in a desk review or an onsite medical review to resolve the problems.

   As detailed above, the State will monitor DMO performance using multiple methods, such as on-site monitoring visits, and continuous monitoring through reports, complaints tracking, number and reasons for opt-outs and enrollee and provider survey results.

   If an issue surfaces in the complaint logs or through the enrollee survey mechanism that points to a poor quality of care, state staff would investigate the issue by interviewing the enrollee and or the enrollee's caretaker immediately contact the appropriate DMO to discuss the issue. If the issue could not be resolved via conference call, State staff would make an on-site visit to the DMO to review the records of the case or cases involved and provide technical assistance to the DMO in preparing a corrective action plan.

   Additionally, the State will contract with the University of Washington to provide outside evaluation of the two DM programs. As part of the evaluation, the Oregon Medical Professional Review Organization will conduct a medical record review to validate data in reports submitted by the DMOs, such as levels of improved lab values on clients enrolled in the DM program.

   The State's Medical Eligibility Quality Control Unit (MEQC) will conduct enrollee surveys (See survey instrument attached as Attachment IV.D.1). The MEQC surveys will validate the information gathered in the DMO enrollee surveys.

2. **Periodic Reviews**: Please describe what areas will be covered in the State's periodic reviews of claims files and medical audits, including the types of care reviewed and how the problems will be resolved. Please include how often these reviews will take place.

   Claims data was collected during a baseline period prior to implementation of the DM program. After a six-month claims "run-out" period, Milliman USA will provide a cost assessment of the program. However, the State will not do a customary claims review because the DMOs will not pay for or provide ongoing medical care.

   OMPRO will conduct medical record review on no less than a yearly basis in coordination with the University of Washington's program assessment.

3. **State Intervention**: If a problem is identified regarding access to care and quality of services problems, the State will intervene as noted below (please indicate which of the following the State utilizes):

(a)	____	Education and information mailing
(b)	__X__	Telephone and/or mail inquiries and follow-up.
(c)	__X__	Request that the provider respond to identified problems
(d)	__X__	Referral to program staff for further investigation
(e)	__X__	Warning Letters
(f)	__X__	Referral to State's medical staff for investigation
(g)	__X__	Corrective Action plans and follow-up
(h)	____	Change enrollee's providers
(i)	__X__	Restriction on types of enrollees
(j)	__X__	Further limits of the number of assignments
(k)	__X__	Ban on new assignment of enrollees
(l)	____	Transfer of some or all assignments to a different provider
(m)	__X__	Suspension or termination as a waiver provider
(n)	____	Other (explain on Appendix IV.E.3.n.)

V. **COST EFFECTIVENESS**:

A. **General**: In order to demonstrate cost-effectiveness, a waiver request must show that the cost of the waiver program will not exceed what Medicaid's cost would have been in the absence of the waiver. The cost-effectiveness section provides a methodology to demonstrate that the waiver program will be less costly than what costs would be without the waiver.

The State should use its Medicaid fee-for-service experience to develop the cost-effectiveness section of the waiver program. When submitting an initial 1915(b)(4) waiver, the State should estimate the cost of providing the waiver services under the waiver and provide a comparison to the projected cost without the waiver. The costs under the waiver may be estimated based on responses to a request for proposals (RFP) from the potential contractors. The amount of the savings may be estimated based on the discount from the State Plan rates represented by the RFP bids. To project the net savings, the State should add any additional costs associated with administering the waiver, to the projected costs of delivering the waiver services without the waiver. All cost comparisons should be made separately for each year of the waiver.

B. **Rationale for Expected Cost Savings**: On Appendix V.B., please explain the State's rationale for expected cost reductions under the waiver program. Include all assumptions made regarding changes due to inflation, utilization rates, State Plan payment rates, and other factors.

Please see Appendix V.B for rationale and cost savings calculations.

C. **Format for Showing Savings Summary**
(Include supporting documentation, i.e., charts, spreadsheets, in Appendices V.C.)

1. The following schedule shows the calculation of the State's program benefit costs under the waiver (if these are not applicable to the State's methodology, please attach the calculations).

Cost Saving Category	Costs Expected Without the Waiver	Projected Percentage of Cost Savings	Total Benefit Savings
TOTAL			

2. **Costs Under the Waiver**

a. Total waiver costs are expected to be $_____ during the two-year waiver period. This includes $_____ in program benefit costs and $_____ in additional costs (management fees, administrative costs, bonus payments if any, etc.) which would not have been incurred had the waiver not been implemented.

3. **Additional Waiver Costs**

The following additional costs are expected to occur under the waiver:

(a) Total additional administrative costs under the waiver, which would not be incurred if the waiver was not implemented, are expected to be $_____.

(b) Additional administrative costs are broken down as follows and a brief explanation of each cost item below:

(1)	.5 FTE	Contract Administration	$_35,700
(2)	____	Systems Modification	$_____
(3)	____	Beneficiary Education, Outreach conducted by State employees	$_____
(4)	____	Beneficiary Education, Outreach conducted by contracted entity	$_____
(5)	.1 FTE	Handling Complaints, Grievances and Appeals	$_8460
(6)	____	Utilization Review System	$_____
(7)	.5 FTE	Additional Staff	$_42,300
(8)	____	Hotline Operation	$_____
(9)	.6 FTE	Quality Assurance Review System	$_50,760
(10)	.3 FTE	Outreach, Education and Enrollment of Waiver Providers	$_25,380
(11)	____	Other (explain)	$_____

FTE costs associated with program are as follows: 1.0 Clinical Consultant, with annual salary plus benefits of $84,600, and whose time is divided among Complaints/Grievances, QA, and Provider Outreach. 0.5 Program Manager, whose annual salary plus benefits are $71,400, and whose time is devoted to contract administration. Additional staff includes section manager and other MAA staff; 0.5 FTE at average of $84,600 to support development and implementation of program. No systems modifications were required for implementation. Beneficiary education is conducted by the contractors, and is included in their program fees. The hotline is also provided by contractors and included in fee. UR activities are included in the QA FTE costs above.

4. **Costs Without the Waiver**

The State projected what the costs would be without the waiver by first calculating the costs during the fiscal year (19 ___) prior to the waiver period. These base year cost data were then projected forward, adjusting for changes in utilization, characterization of affected beneficiaries, changes in payment rates or methodologies and changes in other State policies, to determine what costs would be without the waiver in effect during the proposed two-year waiver period. The documentation to demonstrate what costs would be in the absence of the waiver is presented in Exhibit 1.

5. **Program Savings**

The schedule below shows how savings were calculated under the waiver:

Year	Cost Reductions Expected Under the Waiver	Minus Total Additional Waiver Costs	Program Savings
19____			
19____			
TOTAL			